1995, this problem has been rectified in data from Scottish GUM clinics. Scotland is now in a unique position in the UK, in that we now collect statistics on individuals (with all due attention to preserving anonymity, by using unique identifiers), rather than diagnostic events. These changes have been introduced in tandem with a major review of case definitions and more clinically relevant coding categories.

Our data can now be linked to both demographic and sexual behaviour data, as well as to a clearly definable denominator population. To this end, therefore, the deficiencies to which the authors refer in their paper will no longer apply in Scotland. We are shortly due to commence a local study of sexual behaviour in GUM clinic attenders in Glasgow compared with a control population (in a nearby family planning centre) and we hope that many similar developments will be possible in the future, as a result of this fundamental improvement in the methodology of our data collection.

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Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics

We read with interest the recent paper by David *et al*[1] on urinary symptoms and bacteriuria among male STD clinic attenders. The authors state that *urethritis and UTI cannot be distinguished on clinical grounds and/or urethral smears*. We were surprised that no mention was made of the "two glass urine test" as a means of distinguishing pure urethritis from a combined urethritis/cystitis. We find this a useful test—from January to July this year 11 men attended our department with a documented UTI; nine of these had a cloudy second catch urine (not due to phosphaturia). We would, therefore, be interested to hear whether the authors can provide details of the two glass urine test results in their patients with both bacteriuric and non-bacteriuric urinary symptoms.

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1 David LM, Natin D, Walzman M, Stocker D. Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics. *Genitourin Med* 1996; 72:266–8.

The authors reply:

Although the "two glass urine test" is a time honoured practical in house clinic test, we did not include it in our study. This test in our opinion is subject to observational variation and interpretation. We think that looking under the microscope for quantitative assessment of inflammatory cells is less subject to observer variation and is more scientific. In the Cambridge group only nine of the 11 patients with urinary tract infections had a cloudy second urine, while all the 13 patients with urinary tract infection in our study were found to have pyuria.

LOAY DAVID
DAN NATIN

Antibiotic treatment for gonorrhoea in the UK

The emergence of resistance to quinolones in *Neisseria gonorrhoeae* was highlighted in the review by Ison[1] and in the report by Abeyewickereme and others.[2] However, in the UK quinolones are becoming ever more widely used and have now overtaken penicillin as the drug of first choice. The National Audit of gonorrhoea management questioned all clinics in the UK about cases diagnosed in the first three months of 1995 and received data on 1308 cases, 59% of all reported in the quarter. The antibiotics used fell into the following classes: quinolones 48%, penicillins 40%, spectinomycin 3%, others/not recorded 9%. For those patients known to have acquired their infection outside Europe, and when penicillinase producing *Neisseria gonorrhoeae* (PPNG) was presumably thought to be more likely, the choice (ignoring single use and unspecified drugs) was: quinolones 73%, penicillins 23%, spectinomycin 4%.

Ciprofloxacin resistance is still rare in the UK, but in 1995 the highest ever annual total of ciprofloxacin resistant strains was identified by the Gonococcus Reference Unit, while PPNG isolates were still below their 1992 figure.[3] The Reference Unit data rely on voluntary reporting with its attendant limitations. The National Audit figures show that antibiotic choice has moved away from penicillins, so it is now particularly important that information monitoring the extent of ciprofloxacin resistance is available to UK genitourinary physicians.

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1 Ison CA. Antimicrobial agents and gonorrhoea: therapeutic choice, resistance and susceptibility testing. *Genitourin Med* 1996;72:253–7.
2 Abeyewickereme I, Senaratune L, Prithiviraj VB. Rapid emergence of 4-fluroquinolone resistance with associated decline in penicillinase-producing *Neisseria gonorrhoeae* in Colombo, Sri Lanka. *Genitourin Med* 1996; 72:302.
3 CDR 1996;6:110–1.

Epidemiology of gonococcal and chlamydial infections in Harrow and Brent

Matondo and colleagues report on gonococcal and chlamydial infections in Harrow and Brent.[1] I would agree that it is important to perform such work since it can define "the extent of the problem in the community" and allow for the development of "a profile of STDs in our catchment population".

Sadly, they have done neither of these two since their sampling is limited solely to those using the genitourinary medicine (GUM) clinic at Northwick Park. An earlier study (not mentioned by the authors), also carried out in Brent and Harrow, was able to do both of these.[2] This study was conducted to identify and estimate the proportion of female patients suffering from gonorrhoea, trichomoniasis and candidosis, both with and without symptoms, seeking care or failing to seek care at all. Samples of women in Brent and Harrow were studied in antenatal, gynaecology, family planning, and GUM clinics, and in general practice. This comprehensive study took into account both multiple agencies, subsamples of non-consulters on general practitioner lists, and residents seeking care at STD clinics elsewhere in England, and thus gave a true population incidence and prevalence.

The authors recognise that there are limitations to their study from only sampling attenders at one clinic within Brent and Harrow, but they should not then make claims that infections occur along major transport routes, that there are sex differences among those with gonorrhoea and chlamydia, that the proportion of infected teenagers is small, and about the efficacy of male to female transmission and diagnostic tests. It is a shame that a study that could have formed the basis of important public health interventions within Brent and Harrow has, by its limited sampling, not been able to do so. The asymptomatic nature of many STDs, the fact that even those with symptoms do not always seek care, and that partner notification is not always as effective as one would desire, must mean that people with STDs within the community are potentially not identified by samples taken from clinic attenders. Public health strategy should be based on true population samples, and not limited to attenders at specialist clinics.

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1 Matondo P, Wall R, Morgan K, Hickman M, Dore C, Kapembwa M. Epidemiology of gonococcal and chlamydial infections in Harrow and Brent. *Genitourin Med* 1996; 72:352–7.
2 Adler MW, Belsey EM, Rogers JS. Sexually transmitted diseases in a define population of women. *BMJ* 1981;283:29–32.

Epidemiological treatment and tests of cure in gonococcal infection: evidence for value

In his otherwise excellent review article,[1] Chris Carne makes the classic mistake in his conclusions of quoting somewhat spurious percentages rather than absolute values. He says that 42·6% of treatment failures will be missed if tests of cure are not routinely performed on men with gonococcal infection. However, a closer look at these figures shows that out of the original 4897 men, only 183 (3·7%) were treatment failures, of whom only 78 (1·6%) were asymptomatic; therefore, only 78/4897 (1·6%) of the total would remain infected after treatment if a policy of test of cure for asymptomatic men were not followed; a more meaningful statistic. As Carne himself points out in the article, the cost of identifying each of these very small numbers of cases in America was estimated to be in the range $4900 to $109 800 per case. It might therefore be argued that a more cost effective use of this money would be to

channel it into effective contact tracing which Mark Fitzgerald's paper in the same issue of the journal[2] shows to be an area in which the UK genitourinary service is underperforming.

In this clinic we routinely perform tests of cure on all patients with gonorrhoea but I firmly believe that we should continue to assess even our most ingrained practices and ensure that if at all possible they are evidence based.

GARY BROOK
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1 Carne CA. Epidemiological treatment and tests of cure in gonococcal infection: evidence for value. *Genitourin Med* 1997;73:12–5.
2 Fitzgerald M. Can the management of gonorrhoea be improved? *Genitourin Med* 1997;73:3–4.

MSSVD

Additions to MSSVD Library 1996

Keyes, Edward L. *Urology. Diseases of the urinary organs, diseases of the male genital organs, the venereal diseases.* New York & London, Appleton & Co, 1917. The long account of gonorrhoea in this book gives an excellent description of its presentation and management in the USA at the time.

Clare, Peter. *A practical treatise on the gonorrhoea, with a brief account of the remedies which have been used in Lues Venerea.* Clare was a surgeon working in London. This book contains his views on treating gonorrhoea by urethral injections, a method he had devised for the treatment of syphilis by oral applications of calomel ointment, and a collection of letters between Clare and his patients. Turnbull, William. *A letter to Mr Clare.* Turnbull was a naval surgeon, and in this letter he discussed the value of Clare's mercurial treatment on board ship. This little book is a delight to read.

McDonnell, Robert. *Lectures and essays in the science and practice of surgery. Part 1. Clinical lectures on venereal diseases.* Dublin, Fannin & Co, 1871. The influence of the great Irish venereologists, Colles, Carmichael, and Wallace, is evident, particularly in the long discussion of the treatment of syphilis, which is conservative.

Noguchi, Hideyo. *Serum diagnosis of syphilis, 2nd ed.* Philadelphia & London, J B Lipincott, 1911. Noguchi was a pathologist, working in New York. The book was published five years after the original description of the Wassermann reaction, and contains much detail of the early studies of syphilis serology.

Lee, Henry. *Statistical analysis of 166 cases of secondary syphilis observed at the Lock Hospital.* London, Richards, 1849. The author argues that the treatment of primary syphilis with mercury is effective in preventing secondary syphilis, but only if this is prolonged and thorough.

Innes Williams, David. *The London Lock. A charitable hospital for venereal diseases, 1746–1952.* This is a detailed and entertaining account of the staff and activities of this famous hospital during the years of its existence.

McDonagh, J E R. *The biology and treatment of venereal diseases.* London, Harrison & Sons, 1915. This is a comprehensive text, with far more detail of current beliefs on the pathology and microbiology of the diseases than was usual at the time.

Falck, Nicolai Detlef. *A treatise on the venereal disease.* London, Law, 1774. This is a scarce work. Little is known about the author, who seems to have practised in London. The book opens with an illustrated description of genital anatomy. The account of aetiology and clinical features which follows is conventional; like most of his contemporaries, Falck was a unicist. His treatment was conservative, but he wrote in a discursive and almost holistic style which makes the chapters on management of particular interest.

The MSSVD Historical Library is kept in the Library of the Royal Society of Medicine, 1, Wimpole Street, London W1M 8AE.

J D ORIEL
Honorary librarian

BOOK REVIEW

Genital Skin Disorders. A Guide to Non-Sexually Transmitted Conditions. Edited by RINO CERIO. London: Chapman & Hall Medical, 1995. (Pp 96; £75.) ISBN 0412-55020-2.

Although atlases of vulval disease and skin manifestations of HIV are available, there is little catering, in a general way, for the needs of genitourinary physicians wishing an overview of the skin diseases they may encounter. This book goes part way to addressing that need.

This is a slim, well presented volume with glossy, illustrated pages, that attempts to appeal to a wide audience. In doing so it may have become too simplistic for genitourinary physicians. For example, in the chapter on normal variants of genital anatomy it states "the testes lie in the scrotum". However, other chapters are much more detailed, as well as being written in a clear, informative style. Numerous illustrations and concise tables (especially the table listing common genital skin disorders) make this a useful and enjoyable book to read.

The title is slightly misleading as, in addition to the chapters covering genital ulcers, melanocytic lesions, tumours, and other genital lesions, cutaneous manifestations of HIV disease are also included, suggesting a bias towards dermatology for genitourinary physicians. Genital warts are also mentioned, as are molluscum, scabies, and pediculosis pubis and, although important, they do not necessarily fall under the subtitle of "A guide to non-sexually transmitted conditions". Other topics include diseases of the skin appendages, autoimmune and bullous conditions, and systemic diseases affecting the genital skin, and a useful chapter on the psychosocial aspects of genital skin disease.

Despite these criticisms, the book covers the range of dermatology which a genitourinary physician might expect to see and is provided with a comprehensive index, so "dipping in" is easy. Unfortunately, the price seems high for such a slim volume (which has frequent typographical errors), and this may persuade readers to opt for a more comprehensive dermatological text.

SARAH EDWARDS

NOTICES

ISBS Symposium on Skin Imaging, 16–18 April 1997
The International Society for Bioengineering and the Skin will hold a symposium on skin imaging in Casablanca, Morocco. Further details: Christiane Grillier-Maryse Graner, Service Congrès, Université de Franche-Comté, 1 rue Claude Goudimel, F-25030 Besançon, France. Tel: +33 3 81 66 58 10; Fax: +33 3 81 66 58 12; email: cgrillier@univ-fcomte.fr

Second International Conference on Nutrition and HIV Infection, 23–25 April, 1997, Cannes France
Further details: Dr Thierry Saint Marc, Pavillon P, Hopital E Herriot, 69437 Lyon Cedex 03, France. Tel 33–72–11–01–95; Fax 33–72–33–00–44.

Integrated Sexual Health Services. A model for the future? 30 April 1997
A one day conference to share the experiences of setting up and running an integrated sexual health service. The conference will be held at the Post Graduate Medical Centre, Wexham Park Hospital, Slough, Berkshire on Wednesday 30 April 1997: Further details: Val Britton, Sexual Health Service, The Garden Clinic, Upton Hospital, Slough, Berks SL1 2BJ. Tel: 01753 635603; Fax: 01753 536938.

97th General Meeting of the American Society for Microbiology, 4–8 May, 1997, Miami Beach, Florida, USA
Further details: American Society for Microbiology (ASM), Meetings Dept, 1325 Massachusetts Avenue NW, Washington, DC 20005–4171, USA. Tel 202–942–9297 or 202–942–9206; Fax 202–942–9267.

9th Conference on the Social Aspects of AIDS, 10 May, 1997, London
Further details: Michael Stephens, SIGMA Research, Eurolink Centre, 49 Effra Road, London SW1 1BZ. Tel +44 171 7376223; Fax +44 171 7377898.

3rd International Conference on Home and Community Care for Persons Living with HIV/AIDS, 21–24 May, 1997, Amsterdam, the Netherlands
Further details: Bureau PAOG, Ms Mariska Timmers/Mr Clemens Walta, Tafelbergweg 25, 1105 BC, Amsterdam, the Netherlands. Tel +31 20 566 4801; Fax +31 20 696 3228.

8th European Congress of Clinical Microbiology and Infectious Disease, 25–28 May, 1997, Lausanne, Switzerland
Further details: Administrative Secretariat, c/o AKM Congress Service, PO Box, CH-4005 Basel, Switzerland. Tel +41 61 691 51 11; Fax +41 61 691 81 89.

18th Annual Congress of the European Society of Mycobacteriology (ESM-97), 17–18 June, 1997, Cordoba, Spain
Further details: Congress Secretariat of ESM-97 and ISM-97, Vincit International Agency, Plaza de Espana no LIST18, Toree de Madrid, Planta no 10, 28008 Madrid, Spain. Tel 34–1–5590426; Fax 34–1–5592505.